Meaningful Use Workgroup
Subgroup #2: Engaging Patients & Families
Transcript
May 30, 2012

Roll Call

MacKenzie Robertson - Office of the National Coordinator

Good afternoon, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is the meeting of the HIT Policy Committee's Meaningful Use Workgroup, Subgroup #2, Engaging Patients and Families in Their Care. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself before speaking. I'll quickly go through roll and ask any Workgroup members and staff members to also identify themselves. Christine Bechtel.

Christine Bechtel – National Partnership for Women & Families – VP

I'm here.

MacKenzie Robertson - Office of the National Coordinator

Charlene Underwood.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Here.

MacKenzie Robertson - Office of the National Coordinator

I heard Charlene. We have Leslie Kelly Hall I know is on the line, too.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes, here.

MacKenzie Robertson - Office of the National Coordinator

Neil Calman. Paul Tang. And are there any other Workgroup members on the line?

Greg Pace – Social Security Administration – Deputy CIO

Greg Pace.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Greg. And any ONC staff?

Josh Seidman – Office of the National Coordinator

Josh Seidman.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Josh.

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

MacKenzie Robertson - Office of the National Coordinator

Thanks, Michelle. I'll turn it over to you, Christine.

Christine Bechtel – National Partnership for Women & Families – VP

Great. Well, thanks, everybody, and welcome back to the work of the Subgroup. We, again, really appreciate the time that you're devoting to this. We are going to pick up where we left off on the last call in terms of going through the conceptual framework and working through that. So, just as a reminder, because I don't think, Greg, that we've had you on the phone before, have we?

Greg Pace – Social Security Administration – Deputy CIO

I was on mute.

Christine Bechtel – National Partnership for Women & Families – VP

Okay. So, what we have done is to create this conceptual framework we started with a definition of patient-centered care, from a consumer perspective. We then, with the great input of Leslie Kelly Hall and the work of the Power Team of the Standards Committee, were able to put together a set of key principles and from that we have drilled down into some of the features and functions that would be reflective of those principles and that definition of patient-centered care.

What we've tried to do is kind of capture everything, knowing that we will go back and work through this to make it more parsimonious. So, our path going forward, I think, with your input, is going to be to finish going through the matrix, make sure that we've got everything and then we'll maybe go back through some of the notes and identify what we want to do with any questions that we have or things that might need to be referred to other subgroups. And then finally we'll go back through and really try to achieve some more parsimony in this because it's a little bit of a laundry list right now, but we will go back through it and tighten it up.

And then finally, our overall timing, for those of you who may not know is that by the end of this month we want to try to have a draft set of recommendations that we can present back to the full Meaningful Use Workgroup in July. The full Workgroup will present some recommendations in August to the Policy Committee and, as you all know, the Stage 2 rule is scheduled to come out in September and so we'll do some revising. I think we will definitely have to do some revising in September based on what's in the Stage 2 final rule and then we'll go back through the Policy Committee in October, prior to the release of the request for comment that is expected to go out in December.

So, we've got a couple of calls scheduled. One is June 14th; that's our next call from 9:00 to 10:30 eastern. The next call after that is actually not scheduled until July 20th from 11:00 to 1:00, but depending on how far we get today we may go ahead, I think we should go ahead, and schedule something for the last week of June, at least to get the time held on our calendars so that in case we do need to use that time in anticipation of presenting something to the full Workgroup in early July, then we would have that option.

So, you were sent a while back the revised document that we worked on on the last call and we have a note from we left off. Before we start to dive in and continue working through the framework, does anybody have any questions or comments that they want to raise at this point?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Christine? Can we move, I appreciate the pickup of some of the input from last time, but I was just wondering if we could move the ownership of a person's health at the beginning of the principles rather than at the end and let's… from that, if you will? Just modify it so that we put the ownership and accountability early on and then put what it means a little bit following that.

Christine Bechtel – National Partnership for Women & Families – VP

Okay. I will do that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Thank you.

Christine Bechtel – National Partnership for Women & Families – VP

Great. Okay, so with that let's go ahead and dive into the framework itself. I'm going to do some editing here in real time, again, as we go through it and then we will send out a revised version after the call. So, as you see, we left off at the beginning of the patient-supported empowerment category, which is on page four, and we really left off with view, download, transmit. And we've actually added view, download, transmit and report. And that was really the ability for a patient to either upload information, say, from a specialist into a place of their choosing, whether that's their portal or a personal health record. Or, for perhaps for the patient to be able to report data to another physician that is also caring for them. So, Leslie will correct me if I'm wrong on that, but that is my understanding.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yeah, it's patient reported or patient generated data, so it's just the idea that it's something you can go back to the medical record from the patient.

Christine Bechtel – National Partnership for Women & Families – VP

Great. So, what we have is sort of two categories of things on this list. One is the kinds of information that should be available to the patient and those you can see listed. So, we've got family health history; medication questionnaires for doing medications, so list of medications basically, a med list; patient created health goals; observations of daily living; caregiver status and role; and care team member.

So, these are things that would be in addition to what is already part of Stage 1 and potentially Stage 2, but these are different from those because I don't believe that they were available with the possible exception of, I mean, the med list is available, but this is sort of a medication questionnaire, so it's patient reported med list as opposed to the EHR.

The second category is the kind of functionality, what should patients be able to do or have access to with their information. And so you can see there it's about charting their progress against their care goals or accessing pre-visit tools in order to prepare for their visit. The portal or PHR should be able to receive data from telemedicine devices, the ability to correct errors or add information, a Symptom Checker with health information and links to health information and then online appointment scheduling and RISO requests.

So, why don't we take the first sort of bucket of new kinds of information that the patient might have access to or be able to report and get reactions to that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

We've had a lot of really good input. This overlaps a little bit, but as part of care coordination we're always talking about patient engagement, so things like have been emerging – again, we'll have to bring this together and I know we will in the overall Workgroup – the patient's functional status was an area that was identified as well as kind of interestingly, you know, if a patient through the process is identified to be at high risk, there's something about that patient, you know, this is kind of the risk status of the patient and then there's more monitoring that's done to that patient or they're monitored in a different way.

So, I don't know if that's part – and Leslie might know this – if that's part of functional status, but it's not patient data information, but it's kind of information that's available that, hey, you're at high risk for readmission or whatever they might be at high risk for seems to be information we would want to make transparent to the patient. So, there's stuff that's falling out of the care management or the care coordination process.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And that might be a third area of functionality, which I think Charlene said it really well is getting to the how do I compare or what are the things available to me? What are the correct or evidence-based care plans? What are things that I could be doing or monitoring my own health? What am I at high risk for?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Well, I think functional status is one that they want information on that's viewable, but the other stuff in terms of the patient's risk categories and that kind of stuff I think is information they need to know.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, so I'm going to put central status under the kind of information that's; I mean, it's a funky little division here, and it's a clinic one.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

But it's really stuff that people are using based on functional status to determine level of care.

Christine Bechtel – National Partnership for Women & Families – VP

I'm sorry, Charlene. I think I wasn't clear. The division that we have in the chart is where you've kind of got the types of information or the first several bullets and then you have kind of the functions as the second. I think that's if we design a clean one. We may want to change that, but I'll go ahead for now and put functional status in the first section of the kind of information that is available and then add something about status and how I compare with others under the second piece. Okay, great.

Other comments and thoughts?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think one of the things that we might want to broaden is the idea of these questionnaires or information about adherence because really the patient is the only one that knows, again, whether they've taken the drug, whether they've met the exercise plan, whether they've met the diet plan, so maybe broadening questionnaires for any sort of adherence or reconciliation or response.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, that's a good idea. So, we'll focus medication questionnaires as a way to facilitate med rec and report adherence.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right. But also we could think of questionnaires more broadly because I might want to know what is my status; it comes down to track monitor and track progress against patient care goals below, but just the idea of the patient is the only source of truth for an adherence, whether it's medication or diet or exercise or treatment plans, they're the only ones that know.

Christine Bechtel – National Partnership for Women & Families – VP

Yeah, okay. So, I will have that separate for now. So, we'll call it self reporting of adherence and meds, diet, exercise. Does that make sense?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Or care plan, actually. Okay. I think we have a good sense of family health history. I think patient created health goals is fairly straightforward, as is observations of daily living. We talked about caregiver status and role using the DECAF methodology and we know what a list of care team members is and functional status. I think where I think we need a little bit more specificity is in some of the functionality, so pre-visit prep tools, do we want to cite some examples of that? I mean, that's too broad for a category I think. We have to be more specific.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, pre-visit kinds of information are updates to your family history, your surgical history, your drug history, but it's also things like have you had meaningful consent or meaningful information where the patient is presented all of the choices with regard to the care they're going to have and understand the

care they're about to have and also if there's requirements for the patient prior to the visit they've been informed.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, that's great. So, selecting updated health history, family history, meds, ability to consent to treatment, fill out administrative forms. Does that cover the bases?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yes, and then in more just sort of filling out the forms, is there informed choice. I think Farzad talked about it as meaningful choice, where people can say yes, I really thoroughly understand what this treatment options means.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. And I think some of this, in fact I know, we're going to want to come back and revisit it. A lot of this is data that only the patient will report and, of course, we have a patient generated data hearing coming up in June, so it'll be good to take this information back with an towards what we learn in that hearing.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Absolutely.

Christine Bechtel – National Partnership for Women & Families – VP

Are both of you and, Greg, or are any of you going to be at that hearing in person?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I will.

Christine Bechtel – National Partnership for Women & Families – VP

One of the things I'm thinking is, Leslie, maybe we could ask you because I won't be there, Eva Powell will, which will be great. But maybe we could ask you to kind of bring this, the lens of this work with you to that meeting and report back to us and suggest some potential changes, maybe some ways to achieve some parsimony as an output of that hearing. Would that be okay?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yeah, I'd be happy to.

Christine Bechtel – National Partnership for Women & Families – VP

Awesome. Okay, great. So, our next is, you know, receive data from telemedicine devices. Is that specific enough?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Perhaps we should say and home via medical, telemedicine or biomedical devices or those.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, telemed and biomedical devices, okay. Is everybody okay with that one?

Greg Pace – Social Security Administration – Deputy CIO

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Okay. Information reconciliation, so that's the ability of the patient to correct errors and add addenda. I think that's straightforward. Any comments on that? And then Symptom Checker, health information education. Leslie, I think this came from the Power Team. Can you talk a little bit about this, what that means to you?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

That was the ability for patients to check their symptoms and see what their disposition might be. Do I need to go, am I emergent, can I do self care, so it's not generally a function of the EHR, more patient-facing systems.

Christine Bechtel – National Partnership for Women & Families – VP

Yeah, I was wondering if we needed that one given the sort of prevalence of WebMD, etc., and I think we want to have the locus of our attention really be around information that feeds forward from or that the patient needs to feed into the EHR and things that the patients need to do with their own data.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think that that's probably fair because Symptom Checkers are pretty prevalent. I think the one thing the group talked about is any time I get information from a doctor I should be able to understand it and be able to link to information so that I do understand it, but I think Symptom Checkers are pretty prevalent.

Christine Bechtel – National Partnership for Women & Families – VP

Okay. So, I'm going to go ahead and delete that one then unless there are objections.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And I've joined, Christine. I apologize for being late.

Christine Bechtel – National Partnership for Women & Families – VP

Oh, great. Welcome, Paul. Okay, so I've just deleted that one. That's good, we're getting to parsimony before we're scheduled. The next one we have here is online appointment scheduling and RISO requests. Any comments on that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Are you thinking of making this a requirement?

Christine Bechtel – National Partnership for Women & Families – VP

Well, I think what we're trying to do right now, Paul, we started with the summary definition of patient-centered care. We then took the work of the Power Team and the Standards Committee and converted it into a set of principles and then we've kind done kind of a brain dump, if you will, in here to make sure that the things that are reflective in those principles we have some kind of functionality that captures them. The next step is going to be to go back through and be more parsimonious. But we are looking and trying to keep an eye on all of this, it is either a menu or an option or something, but this under view download, transmit and what we've called from the last couple of meetings and report.

So, that's the question. Does that belong in here? We just took something out that probably didn't and so that's the question on this one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And I might propose that this is not core to our ability to improve outcome. Not because it's not important and this is a very popular thing. It's just what do we focus on because these are independent certifications.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So, Paul, does this fit into like, you know how we were talking on the Quality call the preventative reminders and that type of thing, was this where we would put that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

These are administrative convenience functions. So online appointment scheduling, it isn't a reminder, like patient reminders.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right, but could we replace it with that, I guess is that more in the…

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

This is Leslie. I think that the genesis of this and I think we can either include it or not was unless there's an easy button and people think that they're getting something that makes their life easier do we get adoption. So, I agree with Paul that this isn't something that's going to hugely change the outcomes. It's a question of does it promote adoption when things are easy and convenient. And, if it does, is that within the scope of the recommendations or not?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So, one way to look at it might be to say that it's a strategy for improving the percent of your patients who go online, but that it may not be kind of core to that link between the EHR and the portal or PHR or whatever. So, I'm thinking this probably comes out. As much as I think it's a great thing, I think it's also going to be kind of a market-driven thing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Exactly. The market is already doing this.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, so I'm going to delete, unless I hear objections. Okay, so the new one that we just did discuss and I'll just double-check that I have it right and make sure we would like to maintain it is the ability to compare yourself with other patients. So, see your risk status, understand what evidence-based care for your condition is. And that, Charlene, was something that you added based on the work of some of the other groups.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yeah.

Christine Bechtel – National Partnership for Women & Families – VP

Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

And, Paul, this is my question in terms of is this where we would put the; would we put preventative reminders here?

Christine Bechtel – National Partnership for Women & Families – VP

Well, I think that's patient reminders, right, which we have. I mean this is really what's underneath view, download, transmit and report. And we do have, in the very first line of the table on page two, patient-specific education materials and reminders because that's already part of meaningful use. So, we're trying not to include everything that's already part of meaningful use and reminders is, but here what we're saying is reminders in the top ten primary languages for the top 100 diagnoses, treatments and tests, right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Right.

Christine Bechtel – National Partnership for Women & Families – VP

Okay. So, I think that's covered, Charlene. All right, so the next one is and, again, this is one category where, Leslie, we're grateful for your willingness to be at the Patient Reported Data Hearing and come back and help us make this more parsimonious, that there are two kind of very related things, I think actually one can come out.

We started with there's a section about a patient questionnaire to facilitate self-reported reconciliation, but I think what we've done here is really broadened that to self reporting of adherence generally, be it meds,

diet, exercise or care plans. So, does that make sense? I'm going to delete the med questionnaire and leave in the self reporting of adherence to medications, diet, exercise or care plan.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Changing the track monitor chart progress or is that a separate one?

Christine Bechtel – National Partnership for Women & Families – VP

I think they're inter-related, but, Leslie, help me out because I think that one came from the work of the Standards Committee's Power Team, but I think you want to be able to generate a graph of, you want to be able to sort of see on the page how are you doing against goals, different from self reporting of adherence, which would feed that ability to track progress.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right. One way the team was looking at it is I might have a questionnaire that's coming from my provider that I'm responding to, a very specific, discrete question. But then over time I am tracking my progress, how do I convey that, so I'm like initiating that communication.

Christine Bechtel – National Partnership for Women & Families – VP

All right, is everybody good with those? I'm going to take that as a yes. So, that gets us into the next one that came from the principles is patient decision aids for preference-sensitive care.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

That was around identifying what care is preference-sensitive where there isn't evidence that says one area of treatment is more indicated than another and if patients' values and preferences should be considered and so the discussion about what that might look like seems pretty important, but still needs to be further defined. What are the preference-sensitive cares, how is preference-sensitive care alerted and then what kind of decisions need to be brought forward.'

Christine Bechtel – National Partnership for Women & Families – VP

Right. To me it's akin to some of the patient education linkages to patient education material, so I get it and I think it's a really important goal, but it is one where I think there are just a lot of questions on how to do it and if it should be done through meaningful use is sort of, the second tier question is, well…

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

At today's presentation we heard that 25% to 35% of this particular group of referrals were probably unnecessary, when they did a doc-to-doc communication and the physician who presented also agreed that when the patient could be part of the shared decision-making there might be even more inappropriate referrals go down and when referrals or transitions needed to happen, happened more quickly because there's a high degree of understanding.

So, this is really more about a collaborative care thing, so it's not a binary process where a patient makes a decision on their own. It's actually more of a shared decision making event. So, for instance, the Foundation for Informed Medical Decisions out of Boston, I think it's Boston, has done a considerable amount of work on this, as has Healthwise, but not as much the foundation, and they really look at the patient's participation in this as a way to advance cost and quality.

Christine Bechtel – National Partnership for Women & Families – VP

Which, again, I think is really important, but I think this is one where we have to think about the connection between the electronic health information, be it an EHR or in the portal or PHR, and meaningful use. So, I'm [indecipherable] a little bit. One thought would be, I think there are two approaches that I can think of.

On would be to handle this through a clinical quality measure, because we did actually, the Tiger Team on Patient Family Engagement, so as part of the Quality Measures Workgroup did recommend the refinement of the existing measures on decision quality and the measures weren't quite ready, but they

were getting closer and I don't know if that was one of the contracts that ONC and CMS may have put in place, but that would be one way.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, for instance, how this workflow might work is let's say I'm a patient who is trying to consider surgery and part of that surgery says I need blood and I have a way of deciding whether I want to participate in a transfusion or I want to bank and store my own blood. When the electronic medical record was used by a clinician who now says I'm going to order a transfusion if a patient's preference was indicated as a result of a decision made, it could come up and say, hey, patient has indicated they do not want to have to transfuse blood.

So, patient decision aids themselves are one thing, but it's being able to take any sort of patient preference and integrate it into the workflow. This could be taken to advanced directives, this could be taken to lead products, any religious preference. So, the notion, and maybe this is worded wrong, but the notion of being able to have a patient preference or a patient decision integrated into the workflow so that orders for care can be changes and one aspect of that is preference-sensitive care where we know there's a high degree of variability based upon the patient's preference and where there's a high degree of variability that's where there's an opportunity to reduce cost and to improve quality.

So, do you want me to work on some wording and get it back to you? But I feel real strongly we've got to have something in here about patient decision and preference.

Christine Bechtel – National Partnership for Women & Families – VP

Well, I think what you're describing almost sounds like a decision support rule.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And that's what on the patient side it would be called preference-sensitive care or patient decisioning. It's really getting that back into the work flow.

Christine Bechtel – National Partnership for Women & Families – VP

Right, but so you could have that on two sides. One would be that if there, and this I don't know the answer to, but if there is a list of let's say the top 20 conditions that are preference-sensitive that the EHR actually applies for the provider. Wait-wait, you know, this is something, I mean, in one way everything is preference-sensitive, but in a case where there really is no straightforward answer, then there's a decision support alert that fires for the provider.

On the patient side is different, where that's where you could potentially I guess have the portal link to decision aids to the extent that they are out there.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Right, or a simple questionnaire that goes back to the patient and says what is your decision. So, on the EHR side it's stating that there are conditions that, like preference-sensitive care, that warrant further discussion and decision-making for the patient, so that's the wait-wait that you mentioned. And then on the patient side it could be anything as simple as a questionnaire or as complex as [indecipherable] that you see out there, but something that indicates the patient has a decision and that's been integrated back into the chart.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So, my question would be then and, again, we've struggled with this in some other areas, too, whether it's patients that print sensitive care conditions, specific, because it seems like the variation crosses conditions in some cases, might be condition-specific in other cases.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think you'd have to start small and say what are the highest value preference-sensitive care types and indicate those and then go from there. But the Foundation I think has a hundred that they've said are high value areas where patients' preference can really weigh care treatment choices.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So, the EHR just needs access to that decision table on a patient's perspective, right?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yeah, it would indicate; today, I've got with my diagnosis or treatments or care plan or chief complaint or problem list, I have that identified. I'd need to be able to be flagged that this is a preference-sensitive care option and that it could warrant shared decision aids being sent to the patient and then have the ability to take the result or the response of that back into the record. And I don't know what the right answer here is.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I'm not sure either, but it's like, breaking it down is helpful.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yeah, and where there is preference-sensitive care we have nothing today in our ecosystem or infrastructure that accommodates that that alerts that this exists and that there is further information needed from a patient.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So, I mean, just to kind of move from we were trying to actually push for Stage 2 so that patients' preferences relative to communication decisions would start to get captured. I think this is an important space in that as we start to, whether it's stored in a centralized patient portal or one that's in EHR, that has to evolve still, but this patient preference list, just like we do preferences today, I think is an important concept that we start to build on and evolve over time.

And you can start to add categories of some of these other shared decisions as we evolve it. So, what's their patient preferences, what's their patient care preferences, what's their advanced directive preferences; it starts to build that patient-centric view, if you will.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think you just hit on it, Charlene. I think if we look at advanced directors, they really just indication, a legal indication of a patient's preference and a patient's direction of care and if we kind of look at that more broadly and say there are many patient preferences and directions that need to be considered in care, what would that look like? And that's the next sort of evolving point from both the patient preferences and patient-generated data.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, so what I have is essentially – and then, Leslie, you could maybe refine it as well – is the need to alert providers to the highest value preference-sensitive conditions, which could be a subset, a small subset, from the symptom list.

And then the second is there needs to be a mechanism to collect patient preferences on those particular conditions if they're applicable. There are a lot of, I think there are a couple, probably three or four issues that we've described that really would benefit from a questionnaire. And I'm almost thinking about an approach where you would have an adaptable questionnaire that the portal or the EHR is capable of receiving information from some kind of a questionnaire platform and that could be for preferences on preference-sensitive conditions, but it could be patient experience, it could be a lot of the other kind of patient reported data. But, Leslie, this would be something to kind of keep an eye out for. How do you do that in the patient reported data hearing and how do you do that in a meaningful use context, what's the role of the EHR, what's the role of the online access, things like that?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think that's a good way to put it. There's sort of a gradient of this and I think when we make sure we think about it, patient preferences should inform care and so how do we do that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I wonder if I could sort of take that and what Charlene said and maybe this should be a more generalized requirement and it fits under clinical decision support in the sense that we had those five attributes. Well, another kind of consideration, and this would be an additional feature of the EHR, is when you want to trigger a CDS intervention, remember they sort of generalized it, that it should include consideration of patient preferences and I might state it that broadly.

Because, like you said, we have patient preferences for communication, for advanced directives, for other ways of including their utilities in the decision-making instead of having a line item for every one of the 20 things that we could mention, maybe we generalize this to accommodate patient preferences in clinical decision-making and that feeds into our shared decision-making as well. Does that make sense?

Christine Bechtel – National Partnership for Women & Families – VP

Yeah, that sounds great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That might be a better way than having another line item because all we're doing is adding more and more.

Christine Bechtel – National Partnership for Women & Families – VP

Exactly. Which, Paul, don't worry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

No, I understand. I heard that from you, Christine. I was just helping you.

Christine Bechtel – National Partnership for Women & Families – VP

Right, good, I like it. So, let me make sure I've got it. So, it's essentially that this is something that could fit under the existing CDS part of meaningful use and then you would add; I don't know if it's added, because there's a CDS rule that needs to fire, but then there's also a measure somehow of accommodating patient preferences in clinical decision-making.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, so what you're adding is, we talked about having the right context and the right time of the workflow, etc. Another consideration is the capability of including patient preferences in triggering CDS. And so that's a more general thing and, yes, people would have to think about it and so an accompaniment, of course, would be that you have to have a way of capturing patient preferences. And so, that all sort of ends up getting built in. But the market will drive, when I say the market, well, the individual market or the individual healthcare organization besides what's important here.

I'm a urologist, well, I'm either deciding on whether to get a PSA to whether what I do for BPH. So, when my system is capable of incorporating that, then I will be able to do my job in the best possible way, instead of prescribing for everybody you've got to do the following.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Well said, Paul.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, okay. So, another way to say that, too, would be that essentially kind of the provider would then decide what clinical decisions that this would apply to based on their specialty or the top conditions in their patient population.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. Our interest is in creating the tool, so the certification criteria that will accommodate patient preferences.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, got it. I think that's a great way to do it. Any last comments on that? Okay, the next one we have if after visit summary, which is already part of Stage 1 and 2 and I think we've heard some things from the field that they're not as useful as possible. I know there are a small group of folks who are trying to work with people Peter Basch and ONC and others and us as well to try to understand what the problems are in practice.

The other kind of food for thought I want to throw out there to let people react to is I'm wondering if, in fact, Stage 2 of meaningful use makes online access somehow core, do we need to continue to have a separate requirement for after services summary or should it be rolled into online access or should we somehow build a functionality for visit summary into that or will that already be done in the marketplace and can this come out? So, I'm not sure whether this gets adapted, deleted or just left the same, but wanted to throw those out there.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think this is a placeholder if the after visit summary or the clinical summary document for patients didn't make it in MU2 we need to keep it in. Other than that, I think it's repetitive.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, actually AVS is already part of Stage 1. So, let me clarify a couple of things that came out of our hearing and from our own experience. One is the misinterpretation and Rob… explained it, at least verbally, that when we said we wanted it after 50% of all the encounters it is made available. And remember what we heard was that people were saying, oh, provide means it has to go in printed form in the patient's hands and that's where we got the parking lot comment.

So, Rob clarified that the initial intent, which was the intent of, in fact, this group, was that it was made available one way or another, online being, of course, an acceptable and in some cases preferred way. So, having a patient portal, as an example, available already qualified you for making that available.

So, in some sense, Christine, I think it's already what you said, which is as we move more towards patient portal and more patients want it that way, then we will be fulfilling this part of getting access to your health information. What we have to be careful of is that we also fulfill the need of what to do next after a visit. And so a big component is well, what change, you know, my med changed, I might want to get a diagnostic test, I might want to do certain things; so patient instructions in what changed is an important part of the "after visit summary" as distinct from my entire health record.

So, we want to try to preserve the important function of this after visit information exchange without creating an additional burden. So, I think the things that caused angst amongst folks for a good reason is the lack of clarity in terms of what would fulfill MU1 in terms of providing an after visit summary and making it available online is one way of providing and the other is I think in some of the prescription of what should appear in an after visit summary became too extensive and that the unintended side effect is that when you do print all that stuff, it's five to ten pages and no matter how much good information is inside of ten pages, trying to find it or even carrying that amount of pages, goes away.

So, those are a couple of the major things from the field and we might have an opportunity to adjust it, Christine, to sort of move it in a more normalized direction of what's the problem we're trying to solve and can we do that in the most efficient way possible. Sorry, for the long, lengthy.

Christine Bechtel – National Partnership for Women & Families – VP

No, it's helpful. So, what should we do with it in this case? Do we need to revise it based on what comes out of the rule or do we want to delete? What do we want to do based on all of that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think it's a little bit like what you did for Stage 2. In going from an accessing thing you went to the view, download and transmit. You're sort of going into the more normative direction and maybe we take that a step further. First of all, back up to what's the problem we're trying to solve? One is can you get quick access to the information about your health? That's point one. Then, can I get quick access and clear

access to what do I do next as I come out of this encounter? And I'm using that in a generic sense. It's an encounter in an outpatient setting, it's an encounter in the hospital. What do I do next? If that can be really clear then we have a better chance of having the patient understand and executing the things that would most improve their health next.

Christine Bechtel – National Partnership for Women & Families – VP

Which I think you half of that you get to in a care plan. That's the what do you do next piece. So, I think what we want to do is clarify that the problem we're trying to solve here is click and clear access to information about your most recent health and care and it needs to be information that patients can use to understand what can they do next.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, in this particular line it says after encounter summary we need to focus on what concise information will help them do the best thing for their health next, tomorrow? Sorry?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

And when to call the doctor.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, well, that's included. So, I think the report that was issued has too much information in a nutshell. So, we might want to find ways to think about how to tailor that to make sure we answer the problem that needs to be solved and don't end up with the unintended side effect of having volume.

Christine Bechtel – National Partnership for Women & Families – VP

So, maybe what we could do is on our next call, or between calls, we can have the ONC staff, Michelle, maybe when you send out the notes or the chart that we've revised from today, we can include all of the fields that are required as part of the visit summary and take a look at what we need to do to make them more parsimonious and actionable and concise and then just suggest a revision.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Exactly, and so the question we would ask ourselves is not what would be interesting, but what information would help me know what to do next, knowing that they have access to the entire chart. And I think we ended up dumping the entire chart.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Paul, that's the kind of thing you get pages of lab results out, you know.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yeah, we found that two pages is max and you've got to have what do you do immediately, when do I call a doctor.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Some management.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Yeah, it's very simple.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

That's a great suggestion you had, Christine. Let's see what we have and see how we can make it better.

Christine Bechtel – National Partnership for Women & Families – VP

Yeah. Okay, so the next one is identify evidence-based practices and provide decision support for patients. I think we have captured that primarily up in the view, download, transmit area.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

I think we captured it in Paul's rephrasing of decision support.

Christine Bechtel – National Partnership for Women & Families – VP

Right, that's right, yes, okay. So, I'm going to go ahead and take that out. Delete row, that's always a good thing. The next is receive alerts for drug recalls and set preferences for alerts.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

So, we just came from a patient's testimony, Hugo, in our meetings and we talked about the fact that he's got an implantable device. He does not have access to any of the data that comes from the implantable device. In fact, it's not even being required to send to his electronic health record. It goes back to the vendor. That was just one issue.

And the other is when that device has a recall he doesn't even know about it and so he said how is the patient able to receive information on recalls, on drug, on implantables and other things? That seemed like a high quality issue, but not sure how to phrase it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, maybe one way to look at it is does our current EHR system allow us to facilitate this kind of information from being transmitted? And I would submit, so we actually have this program and interestingly enough we call it the process SNAFU. I forgot what it stands for. So, when something happens, it could be a drug recall, an inadequate, remember the Fluvax that was not working; whatever it is we generate the list and then we distribute the information to the people according to their communication preferences.

So, for the people who are online, that's how they get it. For the others, they'd get a mail, etc. So, one answer to the question does EHR, the way we've described it, give you the ability to deliver this information? It would be yes, because that's what our whole secure patient messaging is all about, for example.

Christine Bechtel – National Partnership for Women & Families – VP

Right, but I also think the precursor to that – tell me if I'm wrong, Paul – is you can generate lists of patients by conditions. We also then I think just said it would have to be also by multiple chronic conditions and it has to be demographic variables. But I assume that you could also easily generate a list of patients who have a particular device or are on a particular med.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Exactly. So, what we recommended, but it wasn't adopted at least in the interim, was multiple parameters so it didn't have to be just diseases.

Christine Bechtel – National Partnership for Women & Families – VP

Right. And so, if the EHR has the ability to do that, then we have not only secure messaging, but you also have, hopefully, record communication preferences. Is there anything else that's needed besides those two things?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes. The kind of thing, and I'm not sure. There's just discussion about these device identifiers now that's starting to emerge, so we've got to know, like if it's a device implantable we happen to have a device identifier, which I don't think a lot of EHRs store yet today. Again, this is going to be how important this is as well as under, and, Paul, you probably know this better than I, but under the medication it's typically a lot number that gets recalled and I'm not always sure that the lot number in all cases is stored in the patient record. I know it's in the pharmacy system.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. So, they generally are not. The only lot numbers we store are injectables, which was a good thing, but that all takes time. So, generally, of course, we don't dispense the meds, so that is a part of the

pharma C system. We're not going to be able to specify everything for every possible condition. So, for example, when a device identifier becomes a standard in it's drug then you know that they're going to be in the EHR system because the marketing, not even marketing, the regulations will require.

So, as long as we have the tool to get the information out by patient reference, I think we're handling this issue, right?

Christine Bechtel – National Partnership for Women & Families – VP

Okay, what I would propose then is that we leave the line in, but have the note column say just to make sure that Meaningful Use Stage 2 includes capturing structured communication preferences for patients and if so, we can delete the row. But if not, then this needs to turn into structured communication preferences.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Are you saying if we, because we did recommend it for Stage 2, but you're saying if it's not, this is a way to reinforce that recommendation?

Christine Bechtel – National Partnership for Women & Families – VP

Exactly. Right. And the recommendation would actually change from receive alerts to collect structured communication preferences, but I'm going to leave it in as alerts just to remind us of the context, but hopefully we'll just be able to delete the row. But I'm going to leave it in as a placeholder to double-check after Stage 2.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

It's sort of tangential, but Charlene brought up a good point about the drugs and the lots in the batch. Is there anything we need to do in preparation for more personalized care, personalized medicine, personalized devices so as a preparatory step? If we think about drugs being mixed specifically for a patient, what do we need to do, if anything, to prepare for that kind of personalized medicine reflected in the EHR? Paul, do you have any thoughts on that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, the preparation, I'm not sure I know what kinds of examples you're thinking of, but you mentioned meds that repair, that would be done in the pharmacy and presumably captured in the pharmacy system. But really the entity that dispenses something is responsible for capturing the important information, like lot number. So, when we dispense, which is inject, vaccines we are the accountable party and, in fact, that's why we record the lot number so we really can send out a recall message.

The same with the pharmacy. When they dispense I believe they know the lot number.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

So, it's just the devices that we have, the implantables that we currently have gaps on being able to identify?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Well, if a patient was on, and often cases they're on a drug and they do kind of a total recall, but if it's a specific lot we might not; you have to know from the pharmacy system which patient, so it's a little bit more complex.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And most devices, of course, are put in in either a procedure or OR, so it would be in a different system, at least a different feeder system. It may still end up going to the EHR.

Christine Bechtel – National Partnership for Women & Families – VP

So, let me try to cut off the discussion a little bit because we're actually at the witching hour here. And we have a full Policy Committee call in 30 minutes and we do actually need 30 minutes between those calls. So, what I'd like to suggest is that on our next call we're going to, we will dive into the ready access

bucket, but I think there's sort of a fair amount of vagaries in here, so I'd like to ask you guys, first of all to think about that and there are three things in there, which is e-business or other kinds of communications, so people have mentioned Skype or eChat.

We're not thinking about those probably necessarily as requirements, but do we want to have the capability to do that and, if so, what does it mean? And second would be administrative forms and I think we need to ask ourselves again is this a convenience thing that the market will drive or something we want to really consider doing.

And the third is the more nebulous role of mobile devices, which is a really big category and we need to understand a little bit more about that and, Michelle or Josh, is ONC doing a bunch of work around mobile devices right now that could inform us or is that different?

Michelle Nelson – Office of the National Coordinator

I'm not sure, Christine.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, we'll find out more about that. So, on the next call what we want to do is dive into that ready access piece, but please feel free to send Michelle or me or copy me yourself ahead of time on that so we can move through it as quickly as possible. We then want to go through and identify which pieces of this table actually should go to other subgroups and not us, like the clinical decision support discussion we have probably needs to get referred over to that group.

And then we also want to go through and think about what can we now take out? What should be a requirement or not and what I'd like to do there is actually develop a set of criteria that might help guide us for how to think about this and so I'm happy to take a shot at a draft, but just some kind of key principles, if you will, around everything in here should be either really important in improving health outcomes or it should be somehow a feed forward or a feed into an EHR, you know, things like that.

So, if you have thoughts on the important way that we need to think about parsimony in here, send that to me and before the next call I'll send out a couple of bullets that people can respond and add to if that sounds good to you all.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Christine, Paul I think or David Bates I think when we were walking through the quality section the other day went back to the original principles that we started with and they resonated pretty well, so you might want to start there as you look at them.

Christine Bechtel – National Partnership for Women & Families – VP

Great. And maybe Michelle can help me find those.

Michelle Nelson – Office of the National Coordinator

Okay.

Greg Pace – Social Security Administration – Deputy CIO

I have one minor suggestion before you leave the patient support empowerment section. When you talk about doing something of choice by patient, I suggest you might want to add by patient or authorized representative.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise

Oh, good catch.

Christine Bechtel – National Partnership for Women & Families – VP

I think we're going to add like a ginormous caveat up there because that applies to everything. So, I'll add that upfront. Okay, great. We're going to go to public comment. Sorry for being a couple of minutes over, guys, but our next call is June 14th from 9:00 to 10:30 eastern, sorry, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

It's been done before.

Christine Bechtel – National Partnership for Women & Families – VP

I know. So, I hope you all can join and thanks for being troopers again. We will send this out in the next couple of days so that you guys can have some time to look at it and give thoughts and have your way with it. So, MacKenzie, do you want to do public comment?

Public Comment

MacKenzie Robertson - Office of the National Coordinator

Sure. Operator, can you please open the lines for public comment?

Operator

Yes. We do not have any comment at this time.

Christine Bechtel – National Partnership for Women & Families – VP

Great. Well, thanks, again, everybody. We will see you before then, but we will talk on June 14th.